April 23, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0823-01-SS

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is a board certified neurosurgeon. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 70 year-old male who was injured when he fell down some concrete steps on ___. The patient reportedly injured his right upper extremity and fractured the right anterior ribs, and experienced pain in the lumbosacral area of the spine. The patient was initially treated the date of injury with bandages to the right upper extremity and referred to a neurologist for a reported problem with walking. After the injury, the patient reportedly fell again on ___ and broke his right wrist. The patient has had X-Rays, myelogram with CT scan following, and CT scan of the lumbar spine. The diagnoses for this patient include disc bulge at L3/L4, mild facet hypertrophy L4/L5 and L5/S1 and hypertrophic osteophytes at all lumbar levels. The patient underwent a discectomy on 10/17/01.

Requested Services

Spinal Surgery.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this patient sustained a work related injury on ___. The ___ physician reviewer also noted that the patient's diagnoses included disc bulge at L3/L4, mild facet hypertrophy L4/L5 and L5/S1 and hypertrophic osteophytes at all lumbar levels. The ___ physician reviewer indicated that this is a patient with minimal spinal stenosis, questionable radiculopathy and previous lumbar decompression. The ___ physician reviewer also explained that this patient is of advanced age with continued back pain. The ___ physician reviewer further explained that there is no clear role for complex reconstructive procedure for this older

patient. Therefore, the ___ physician consultant concluded that the requested spinal surgery is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 (ten) days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 23rd day of April 2003.